10.0.0 INSTITUTIONS

10.1.0 Institution

For MA purposes, "institution" means medical institution. A medical institution can be, but is not limited to, skilled nursing facilities (SNF), intermediate care facilities (ICF), institutions for mental disease (IMD), and hospitals.

Medical institution means a facility that:

1. Is organized to provide medical care, including nursing and convalescent care,

2. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards,

3. Is authorized under State law to provide medical care, and

4. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

10.1.1 Institutions for Mental Disease

IMDs are medical institutions that care for persons with mental illness. See the list of IMDs (10.10.0).

10.1.1.1 Eligible Age

IMD residents under age 21 and over age 64 may be MA eligible. Persons aged 21 through 64 are not unless they were IMD residents immediately prior to turning age 21. If they were, they are eligible until discharge or until turning age 22, whichever comes first.

10.1.1.2 Temporary Leave

A person aged 21 through 64 can go on conditional release from an IMD or convalescent leave and become eligible for MA while on leave.

1. Conditional release means a temporary release from an IMD for a trial period of residence in the community.

   - The trial period must last no less than four days. It must be no longer than 30 days.

   - The trial period begins after the initial three days of community residence following discharge.

10.1.1.2 Temporary Leave (cont.)

- A person under age 22 who leaves the IMD for a trial period remains eligible as an IMD resident until s/he is unconditioanally released from the IMD.

For purposes of MA, conditional release is permitted only once every calendar year.

2. Convalescent leave means a temporary release from an IMD for a trial period of residence in the community. The trial period must last no less than four days. It must be no longer than 30 days.

10.1.2 Hospitals

Hospitals are medical institutions that:

1. Provide 24-hour continuous nursing care,

2. Provide dietary, diagnostic, and therapeutic services, and

3. Have a professional staff composed only of physicians and surgeons, or of physicians, surgeons and doctors of dental surgery.

A person residing in a hospital is an institutionalized person (10.4.1) if s/he:

1. Has resided in a medical institution for 30 or more consecutive days, or

2. Is likely to reside in a medical institution for 30 or more consecutive days.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

10.1.3 Minors in IMD

When a minor applies for MA after being discharged from the IMD, certify the individual as a recipient, if eligible, for the inpatient IMD days only. Certify for the remainder of the month if s/he would be eligible after being tested for Family MA with his/her parents and siblings.

10.2.0 Licensing & Certification

Medical institutions (SNFs, ICFs, IMDs, hospitals) are licensed under Chapter 50, Wis. Stats. The Division of Public Health, Bureau of Quality Assurance, is the licensing agency.

10.2.0 Licensing & Certification (cont.)

In order to receive MA payment for the care and services they provide, medical institutions must comply with federal MA requirements. The agency which certifies their compliance is the Division of Health Care Financing.

10.3.0 Facilities Not MA Certified

Determine the eligibility of persons in non-certified facilities in the same way as for those in certified facilities. MA will not pay cost of care for these persons, but they may still be eligible for MA card services (14.15.0).

10.4.0 Definitions

10.4.1 Institutionalized Person

"Institutionalized person" means someone who:

1. Has resided in a medical institution for 30 or more consecutive days, **or**

2. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

For purposes of divestment and spousal impoverishment, consider community waivers participants to be institutionalized.

An exception to the 30-day period is that a resident of an IMD is considered an institutionalized person until s/he is discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

10.4.2 Community Spouse

A "community spouse" is:

1. Married to an institutionalized person, **and**

2. Not living in a nursing home or other medical institution for 30 or more consecutive days.

10.5.0 Asset Limit

See 30.5.0 for the EBD asset limits for an unmarried client.

See Appendix 23.0.0 for information about how to determine a married client's asset limit and the community spouse asset share.

If assets exceed the limit, s/he is ineligible.

10.5.1 Divestment

See Appendix 14.0.0.

10.6.0 Monthly Need

Monthly need is the amount by which the institutionalized person's expenses exceed his/her income. It is computed by adding together the following monthly costs:

1. Personal needs allowance (30.5.1).
2. Cost of institutional care (use private care rate).
3. Cost of health insurance (10.6.3).
4. Support payments (15.3.2.1).
5. Out-of-pocket medical costs.
6. Work related expenses (15.3.4).
7. Self-support plan (15.3.2.2)
8. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court ordered attorney or guardian fees.

10.6.1 Hospitalized Persons

When you determine a hospitalized person's monthly need use the average daily charge for the hospital the person is in. See Appendix 30.9.0. If his/her hospital is not on the list, enter $2,318.08 on ANII.

10.6.2 Both Spouses Institutionalized

If both spouses are institutionalized and one has income greater than his/her monthly need, calculate the couple's combined monthly need and compare it to their monthly income. If their combined monthly need exceeds their combined monthly income, both spouses may become eligible.

10.6.3 Health Insurance

Allow health insurance costs only if the primary person is the owner of the policy and is billed for the premium.

Do not deduct health insurance premiums for health insurance that pays for more than the cost of medical care. An insurance policy which pays for accidental injuries, does not qualify as a health insurance premium and cannot be deducted.

When a person pays premiums less often than once a month, prorate the premium to find the monthly amount. Deduct the monthly amount from the monthly income.

The accumulation of these premium amounts is an exempt asset. Exempt them for a period over which they have been prorated.

10.6.3 Health Insurance (cont.)

Example. Mr. W. pays a health insurance premium of $600 every quarter. The monthly amount, prorated over three months, is $200. Deduct $200 from Mr. W's monthly income. Each quarter, exempt $600 of Mr. W's assets until that quarter's premium due date.

10.6.3.1 Nursing Home and Hospital Insurance

Nursing home and hospital insurance polices are indemnification policies. Indemnification policies provide benefits in a fixed amount for a confinement, such as a hospitalization, regardless of the expenses actually incurred by the insured.

Nursing home and hospital insurance policies pay a flat rate to the policy holder for each day that s/he resides in the nursing home or hospital, respectively.

Consider nursing home and hospital insurance as a type of medical insurance. Allow the premiums as a deduction in the eligibility test and post-eligibility calculation.

10.6.3.2 Assignment of Nursing Home and Hospital Insurance Payments

All clients must cooperate in providing Third Party Liability (TPL) coverage and access information (38.3.5). All clients must sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (38.3.5.1). Terminate eligibility for any individual that will not cooperate in:

- Providing TPL coverage and access information.
- Turning over payments from indemnity insurance policies.

10.6.4 Support Payments

Support payments are payments which an institutionalized MA client makes to another person for the purpose of supporting and maintaining that person. See 15.3.2.1.

10.6.5 Fees to Guardians or Attorneys

See 15.3.2.3.

10.7.0 Cost of Care Calculation

After you have determined that an institutionalized person is eligible for MA, you must calculate his/her cost of care. Cost of care is the amount s/he will pay each month to partially

10.7.0 Cost of Care Calculation (cont.)

offset the cost of his/her MA services. It is called the patient liability amount when applied to a nursing home resident, and cost share when applied to a community waivers client, Pace/ Partnership, or Family Care client.

Calculate the cost of care in the following way:

1. For a MA client in a nursing home who does not have a community spouse, subtract the following from the person's monthly income:

   a. $65 and ½ earned income disregard (15.3.6).
   b. Monthly cost for health insurance (10.6.3).
   c. Support payments (15.3.2.1).
   d. Personal needs allowance (30.5.1).
   e. Home maintenance costs, if applicable (15.3.1).
   f. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees (15.3.2.3).

2. For a MA client a nursing home who has a community spouse, follow the directions in 23.0.0.

3. For a community waivers client with or without a community spouse, follow the directions in 25.0.0.

4. For a hospitalized person, there is no cost of care. There is no system available yet to collect a hospitalized person's cost of care.

5. There is no cost of care for SSI recipients.

6. For a MA client who was or could have been certified through a deductible before entering the institution, there is no cost of care until the deductible period ends.

If the patient liability amount is equal to or more than the nursing home's MA rate, the person must pay the full nursing home cost. If there is income left over after paying the nursing home cost, the person must pay his/her medical bills up to the amount of the excess income. MA will pay the balance. The person must pay his/her obligation before MA can be billed.

10.7.1 Hospitalized Persons

Do not calculate or report a patient liability for a hospitalized person. See 10.7.4.2 and 10.7.4.3 for information about patient liability calculations when a person transfers between a hospital and nursing home(s).

10.7.2 Managed Care Programs

Payment procedures are different for institutionalized Family Care or Pace/Partnership clients. These clients pay their cost share to the Managed Care Program instead of to the nursing home. The program then pays the nursing home.

10.7.3 Partial Months

If a client is not MA eligible and residing in an institution (10.1.0) as of the first of the month, there is no patient liability for that month.

10.7.3.1 Death

If the patient liability amount in the month of death is greater than the nursing home's cost of care for that month return a completed 3070 form by:

Mail: EDS
P.O. Box 7636
Madison, WI 53707

E-mail: eds_3070@dhfs.state.wi.us

Fax: (608) 221-8815

Indicate the patient liability amount as equal to the nursing home charges for the month. This is done for potential retroactive nursing home rate adjustments. The nursing home will notify the Estate Recovery Program (ERP) of who received the excess income. ERP will attempt recovery even if the money goes to the heir directly. ERP uses the same process to recover this excess income as it does for recovering patient fund accounts (21.5.7).

10.7.3.2 Community and Nursing Home

There is no patient liability in a month a client moves from:

- The community into a nursing home after the first of the month, **or**
- From a nursing home to the community before the end of the month.

10.7.4 Transfers Between Institutions

When an institutionalized person transfers between institutions, calculate the patient liability due each institution. Send a completed Notice to Institutions, Nursing Home, Client form (DES 3030) to notify the client and institution. Return a completed Medicaid/BadgerCare Certification form (DES 3070) to EDS.

10.7.4.1 Transfer between Nursing Homes

If a client transfers between nursing homes, follow this procedure to divide the patient liability amount between them:

1. Divide the monthly patient liability amount by the number of days in the month of change. This results in the daily prorated amount.
2. Multiply the daily prorated amount by the number of days in the month of change that s/he resided in the first nursing home. Allocate the resulting amount to the first nursing home.
3. Multiply the daily prorated amount by the number of days in the month of change that s/he resided in the second nursing home. Allocate the resulting amount to the second nursing home.

Note: Do not count the day of the move twice. Count it for the nursing home to which s/he moved.

10.7.4.2 Nursing Home and Hospital

The entire patient liability amount is paid to the nursing home if a client moves from:

- A nursing home to a hospital, **or**
- A hospital to a nursing home, **and**
- S/he has been continuously institutionalized for 30 days or more.

10.7.4.3 Multiple Nursing Homes and a Hospital

If a client moves from a nursing home to a hospital to a second nursing home, do not apply the income to the patient liability while in the hospital. The income is divided differently according to the timing of the moves.

If the client resides in two different nursing homes and a hospital all in the same month, divide the hospital days evenly and allocate those days to each nursing home. Then do the prorated calculation described in 10.7.4.1.

10.7.4.3 Multiple Nursing Homes and a Hospital (cont.)

Send a Notice to Institutions, a Nursing Home, Client form (DES 3030) to the client and the nursing homes.

If the move to the hospital is mid-month and then to the second nursing home is in another month, the first nursing home gets the entire liability amount for month one and the second nursing home gets the entire liability amount for month two.

10.7.5 Retroactive Cost of Care

Occasionally a nursing home or community waivers applicant becomes retroactively eligible. This might happen, for example, when a person, having been denied eligibility, goes to a fair hearing. If the fair hearing determines the person was eligible at the time of application, the agency must retroactively certify him/her and compute retroactive cost of care. The directions are the same as for current cost of care (10.7.0).

10.7.6 Personal Needs Allowance

Deduct the personal needs allowance (30.5.1) for all institutionalized clients in both the eligibility test and the patient liability calculation.

10.7.7 Payment for Non-Covered Services

MA clients in nursing homes are allowed to pay for some medically necessary non-covered services out of their patient liability. They are not required to use their personal needs allowance for these services. Refer clients to their provider to make this adjustment.

10.8.0 Nursing Home Contracts

Certain nursing home contract provisions require prospective residents to be on private pay status for a period of time, usually 12 to 18 months, before applying for Medicaid (MA).

In essence, this requires the prospective resident waive the right to apply for MA for a period of time as a precondition to admittance. The prospective residents, who are typically on a higher private pay status at the time, would generally qualify for MA before the contract provision expires.

Nursing homes must honor residents' rights guaranteed by HSS 132.31, Wis. Admin. Code, in order to participate in the MA program. The standards must be enforced as a condition of federal funding. They apply to all residents in an MA certified nursing home, both MA and private pay, as a condition of participant in the MA program.

A resident can be involuntarily discharged or transferred essentially only for: (1) medical reasons, (2) his/her welfare

or that of other patients, or (3) nonpayment. Changing status from private pay to MA and any corresponding loss of revenue to the nursing home are not to be considered nonpayment.

Thus, contract provisions prohibiting a person from applying for MA by requiring a certain length of stay as a private pay resident can't be enforced by threats of discharge.

DHFS has notified all Wisconsin nursing home providers that: (1) violations of private pay duration of stay contract provisions aren't grounds for discharge, and (2) they must notify all present and prospective residents of this.

10.9.0 Nursing Home Refunds

When an institutionalized person becomes eligible for MA, s/he is certified with a begin date of the first of the month in which s/he became eligible. If s/he prepaid his/her patient liability for that month, s/he is entitled to a refund. The nursing home must refund the amount s/he prepaid in the month in which s/he became eligible.

Treat the refund as a reimbursement in the month it is received (15.2.8). Do not count it as income in the month it is received. Beginning with the month following the month of receipt, count any amount s/he keeps as an available asset. S/he can avoid having the reimbursement counted as an available asset by doing any of the following:

1. Transfer it for fair market value for an exempt asset.

2. Transfer it to his/her spouse.

3. Refund it to the MA program in an amount equal to what MA has already paid for his/her care up to the date of the reimbursement.

10.10.0 Liability Effective Dates

Nursing homes, State centers, and State mental hospitals receive a CARES weekly paper report, #CCN150RA, that lists the patient liability amounts for their MA residents. The report includes case number, primary person name, patient liability status (approval, closure, increase, decrease, unchanged), the date the action was confirmed on AGEC, prior patient liability amount, current patient liability amount, effective begin date, and effective end date.

Income changes which are reported timely and result in an increased patient liability have the following effective dates:

10.10.0 Liability Effective Dates (cont.)

1. Before cutoff, effective the first of the following month.

2. After cutoff, effective the first of the month after the following month.

Do not complete DES 3070's for retroactive patient liability increases since the client must receive timely notice.

Decreases in patient liability are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later. If the date of change that you enter into CARES will cause an incorrect effective date on the EDS file, run with dates in CARES. Do not complete a DES 3070 unless you are unable to confirm the decrease after running with dates in CARES.

10.11.0 Institutions for Mental Disease (IMDs)

Brown
Bellin Psychiatric Center
Brown County Hospital
Libertas

Dane
Mendota Mental Health Institute

Fond du Lac
Fond du Lac County Health Care Center
Marathon
North Central Health Care Center
Norwood Health Center

Milwaukee
Milwaukee County Mental Health Complex
Milwaukee Psychiatric Hospital
Rogers Memorial Hospital

Waukesha
Rogers Memorial Hospital
Waukesha County Mental Health Center

Winnebago
Winnebago Mental Health Institute

If you have a question about an institution on this list, contact:

Division of Health Care Financing
Harvey Aures, Telephone: (608) 267-9698
Dave Bodoh, Telephone: (608) 267-9589